RESTRUCTURING THE FINANCING OF HEALTH CARE: MORE STRINGENT REGULATION OF UTILIZATION*

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ISSUES related to the utilization of medical care services will, I believe, dominate much of the health policy agenda for the balance of this decade. Indeed, almost all of the nostrums or panaceas proposed for dealing with the problems of health care costs really, in one way or another, focus on utilization issues, if you examine them. Further, I suspect that we shall try all of those nostrums and panaceas simultaneously.

I start from a very simple equation: total expenditure equals price times quantity. In health care we have long argued whether the problem is the price or the quantity. That argument can go on indefinitely, but we are getting to be pretty good at controlling price, at least for hospitals, and we have successfully controlled nursing home prices for almost a decade. We have, in Diagnosis Related Groups, whatever else might be said about them, a reasonable working definition of a product to which one can attach a price. We are also getting closer to fixing prices for other kinds of services, although it must be recognized that, in terms of direct fees to physicians or certain other categories of health care expenditures such as drugs, unit price has not been the problem in the last few years, since those unit prices have increased less quickly, in many instances, than the consumer price index. The real problem has been quantity, in a number of ways. So we must address quantity issues.

There has been some discussion already at this conference as to whether or not there is still a sizable amount of fat in the health care delivery system, at least in a setting like New York where financial constraints have been in place for some time. At some point that becomes a rather

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sterile argument: one man's fat is another's muscle. More important, those debating this issue may increasingly be talking past one another, if one side is talking quantity and the other price. In New York, for example, it is hard to find significant excess in the per diem routine services costs, or per unit ancillary costs for most departments, but one can legitimately raise a host of questions about the volume of days and ancillary services. Similarly, throughout the nation it is hard to argue that the bulk of line hospital personnel are overpaid, but whether they are all employed productively—whether we really need so many—is another issue.

Let me illustrate what seems to me most provocatively to suggest the existence of fat and thus suggest issues of concern. In 1978, for all ages in the population, adjusted for different age distributions, the West census region—these are gross statistics—used about 884 hospital days per 1,000. The North Central region used about 1,400 days per 1,000, or about 60% more. Looking only at Medicare, in 1978 again, we in the Northeast can claim first place per 1,000 Medicare beneficiaries, age adjusted—almost 4,100 days of acute inpatient care. In the West the figure was about 2,700 days.[1] The weather is better out West and there are more nursing homes there. But I would suggest that the assumption that we are all buying equally high-quality services, without waste in both settings, should not be taken entirely on faith. It is certainly far from clear that invariably or universally 4,000 days is wasteful and 2,700 is effective or efficient. But there should be some presumption that something is going on.

Medicare's cost per beneficiary, the famous AAPCC (or Average Annual Per-Capita Cost) is almost three times as great in metropolitan Miami as it is in metropolitan Tacoma, Washington.[2] The weather in Miami is better, so that cannot be the issue. Not only could one presume that something is going on that could probably be eliminated without terribly adverse consequences for the health of Medicare beneficiaries in Miami, but, if nothing else, tax payers in Tacoma are subsidizing an awfully large income transfer to pay for something the value and efficacy of which is not entirely proved.

We have known for a long time that Kaiser, of course, can serve its population for about 350 inpatient days per 1,000. Blue Cross plans serving comparable populations require 500 or 600 days. Kaiser is not alone. The Harvard Community Health Plan aims at the same target. It turns out that fee-for-service practices generally both admit more people to hospitals and keep them there longer; the differential advantage of health

maintenance organizations in hospital utilization involves both length of stay and volumes of admission.[3]

Finally, Stanley Wallach of Brandeis, the principal activist on behalf of so-called social HMOs for the elderly, has suggested that, based on experience of HMOs that have enrolled Medicare beneficiaries, social HMOs, if operated effectively, can reduce Medicare inpatient utilization by 25%.[4] That 25% may not be fat, but something certainly calls for attention.

These variations in practice patterns and resource use—these utilization issues—call for attention for three reasons. One, it looks embarrasing, *à priori,* for the medical and the health professions. Second, and more important, although not centrally important, the way to beat price control is to increase volume. The way to beat per diem rate controls is to increase the length of stay. The way to beat DRGs is to increase admissions. The way to beat control on physician fees is to perform more services. If one considers controlling expenditures from the point of view of a given program, price controls, in and of themselves, are not adequate.

I think that the most important reason to pay attention to utilization, however, is that we cannot save enough with price control alone. Washington is now preoccupied by the Congressional Budget Office projections for the future of the Hospital Insurance Trust Fund. It shows the power of compounding to talk about a $300 billion deficit by 1997.[5] But what is perhaps most important about this study, apart from the way it affects the political future of Medicare, is that it is based on reductions of 3% per year in the growth rate of Medicare hospital payments. If that growth rate is reduced by another 3% per year, the deficit disappears. Put another way, to keep the Trust Fund solvent without a tax increase or reduction in Medicare benefits is to bring the rate of growth in Medicare's hospital care to 1.5% per year *below* inflation. On the other hand, Congress now seems to feel, at least as reflected in the last two years' legislation, that the best we can do, in terms of controlling payments to hospitals, is inflation plus 1% plus volume. That just does not save enough money; it also increases the share of resources going to the health sector, in a compounding way, unless we do something about utilization.

One reason that Congress pegged the growth of payments under Medicare to inflation plus 1% is recognition of the continued development of new technologies that increase expense. I cannot resist suggesting, almost by way of digression, that it is really rather remarkable how we have

come to assume that all new technologies increase costs. First, that would characterize the health care industry as unique; second, it runs contrary to much of our experience with new technology in almost every other sector of the economy; and third, I am not sure it really fits the empirical evidence. Of course, bypass surgery, as opposed to medical management of coronary artery disease, is both a major qualitative improvement and a great increase in expense. On the other hand, the treatment of peptic ulcer with cimetidine is both a great qualitative improvement and an enormous reduction in expense. I just am not sure that when we say that costs are going up because of new technology that that is entirely correct. Technological determinism remains popular with some historians and many economists, but political scientists know better.

In any event, there is clearly a growing consensus that as we try to do something about costs, we are, de facto, going to do something about prices, but we have to do something about quantity as well. The question is: how are we going to do it?

There are, I would propose, six general approaches. All of them, I would predict, will be tried simultaneously. I shall describe them very briefly without too much evaluation.

The first approach to utilization, obviously, is capitation. Pay some organization or intermediary and let them worry about the mix of inputs, broadly defined, that they will use for a defined population. A classic HMO is an excellent example. HMOs continue to grow, albeit slowly, in terms of their market share. Some people are now quite optimistic that the new provisions for Medicare contracts with HMOs will substantially encourage Medicare enrollment.

One can also talk about a variation on prepaid capitation discussed at length elsewhere in this conference, primary care case management. That can be arranged with or without financial risk for the primary care case managers. It can be arranged for Medicaid or for any other population one wants to talk about. Obviously, once John Iglehart wrote about it in *The New England Journal of Medicine*,[6] it acquired a certain status of something at least worth attention, and I think it is.

Capitation as a payment mechanism, it should be noted, can be the key element in either a so-called procompetitive strategy or in a very highly noncompetitive strategy, such as the last draft—when people were still paying attention to it—of the Kennedy-Corman bill, which essentially capitated the nation at a statewide level. In either case, the advantage that both of those reveal for capitation is that price and utilization control are

fully integrated in a potentially very effective way.

Second, one can attempt to get at utilization by making consumers more price sensitive. One can make them more price sensitive at the point of service by copayments and deductibles, or make them more price sensitive throughout the year by the ways in which employee benefits are structured. I shall withhold evaluation of that general approach other than to suggest that we shall see increased consumer price sensitivity in the future, no matter what. More generally, I shall defer to vanity and simply cite myself.[7]

The third thing that can be done to get at utilization is to constrain the inflow of resources into the health care sector. We shall continue to do that with capital. As surprising as it may be that Congress adopted a national DRG system, just wait until it adopts a new national certificate of need program! Two or three years ago, of course, no one would have thought we would ever see that. The failure of certificate of need programs to date, I believe, has largely arisen from the absence of either an adequate "technology" or adequate incentives for health planners adequately to constrain the inflow of capital. If inferences about the ineffectiveness of certificate of need programs are based on the experience relative to investment in hospitals during the last 10 years, one ought to look at what has happened to nursing homes, and one can draw very different conclusions about how effective capital supply controls can be.[8]

What one really does when attempting to constrain capital expenditures is, in fact, not attempting to constrain capital expenditures *per se,* but attempting to constrain utilization. People knew that when they first started talking about capital controls and certificate of need, although they may have forgotten it as interest rates got so high and capital expenditures, in and of themselves, became more visibly costly. But the real issue is that resources that do not exist tend not to get used; that is the inverse of Roemer's law. One reason why all of the evidence shows that whatever else the effects of DRG-based payments in New Jersey have been, the most obvious gaming response to be undertaken by providers—substantially increasing admissions—has not occurred, is because inpatient acute bed capacity is very tight in New Jersey. Unless length of stay is reduced very drastically, it is very hard to increase admissions; hospitals do not have a lot of beds available. (That suggests that there may be different sorts of effects from DRGs in other parts of the country, but that is another issue.) Similarly, the evidence does seem to show that one of the reasons HMOs can control utilization so effectively is that they put at the command of

their physicians and of their enrolled population a relatively smaller supply of resources, and thus require their physicians to allocate those resources more intelligently.

The fourth thing that can be done to affect utilization is what might be called payor command and control. We are, I am quite impressed to say, seeing substantially more of that in the private sector at the moment than we are in the public sector. There are the very initial halting steps of the Blue Cross-Blue Shield Association to list 48 or 50 procedures that they will not pay for at all. We have another list from Blue Cross-Blue Shield of certain surgical procedures that they will pay for only on an outpatient basis. One might say that these sorts of things are not the heart of the cost problem, but there are at least five hospitals in the State of New Jersey—I do not know how many there are in New York—where "miscellaneous diseases of the teeth" are one of the five leading admitting DRGs. Employers and business coalitions, on their own, are paying a lot of money to consultants these days to set length of stay norms by admitting diagnoses and informing hospitals that they will pay for only so many days. They are instituting pre-admission screening and analyzing usage patterns and costs to steer insureds toward or away from particular institutions. A lot of activities of that kind are going on in the private sector, and the public sector will not be terribly far behind.

Fifth, to control utilization one can employ peer processes, broadly defined, to affect the behavior of physicians. That tends to be the favorite suggestion of organized groups of physicians, and the fact that it is may make others excessively skeptical about them. But they often do work. Walter McClure has made a very valuable contribution with his writings about the experience at the Mayo Clinic, a large-multispecialty group practice with a reputation for providing high-quality medical care, but not on a prepaid basis. Mayo is a fee-for-service group. Nonetheless, the utilization patterns, in terms of inpatient days, ancillary services, cardiac catheterization, and the like, in the population served by the Mayo clinic, substantially more resemble utilization patterns from HMOs than utilization patterns in conventional fee-for-service practices. McClure suggests that some social phenomenon involving physicians at the Mayo Clinic affects their behavior.[9] I suspect there's a lot to be learned from how that process works.

Wennberg and some of his colleagues at Dartmouth Medical School and the Maine Medical Society, under a grant from the Commonwealth Foundation, developed a series of reports on intrastate variations in

utilization of hospital services and surgical procedures from one community to the next. The Maine Medical Society is now planning to undertake a major educational effort with its members to try to bring utilization of tonsilectomies, hemmorhoidectomies, hysterectomies, and so forth down in the high utilization areas, and they will succeed. A number of specialty societies in organized medicine and other groups now devote infinite hours in meetings, in a variation of the NIH consensus process, to try to come to professional consensus on appropriate indications and norms for certain tests or procedures, or for admissions or for discharges. Those reports will eventually be issued, and they will have some influence, apart from all other factors, on the behavior of physicians.

Finally, there is this odd beast called the PRO. Brown has suggested that one of the greatest direct accomplishments of Reaganomics in health legislation has been the reduction of the acronym for PSROs by 25%.[10] But I think that the transformation from PSROs to PROs, at least potentially, is really quite important. It represents a very explicit recognition by the Congress that one cannot have a price control system and be concerned about budget stability unless someone is watching utilization, necessity, and appropriateness. Further, the PRO legislation clearly recognizes that there is no particular logic in having an organization of that kind work only with federally-insured clients. Third, the PRO legislation reflects recognition that, while it is vitally important to have physicians in the process, it is not necessary to have organizations that are governed by or accountable to physicians in order to do an effective job. And, fourth, I think it represents a useful building on the experience with PSROs along the following lines: we have, or the Congress thinks we have, a technology to identify potential or actual problems of utilization, necessity, or appropriateness. What does not exist at the moment are social, political, and administrative mechanisms to do something about them. It is very easy to say that there appears to be a problem; it is very hard to figure out what to do about that problem. The current PRO legislation by no means solves that question, but does represent a very serious commitment by the Congress to keeping that issue on the agenda of lots of people in the health care system because it will not go away. Sooner or later, it has to be resolved.

Let me summarize and conclude by saying three things about all of these undertakings. First, as previously noted, all six approaches will be tried. They will all be tried simultaneously, to a greater or lesser degree, in different parts of the country. It is probably important to note in

passing, to the extent that it has not been earlier in this conference, that while we talk about future developments in national policy, it is increasingly an illusion for those of us concerned with policy to believe that this is one nation. Even Medicare, which is the closest thing we have to a national health care program, now, in its rules for payment for inpatient hospitalization (which, of course is 90% of Part A), applies to only 82% of the population. The other 18% live in four waivered states. Within three years the odds are very good that there will be substantially more than four waivered states, with substantially more than 18% of the population. Within the last 18 or 24 months, moreover, the Reconciliation Act changes and the responses of the states to them have sent Medicaid off in a variety of directions. Private insurers are going in one direction in the very different market that they face west of the Rockies than in the Blue Cross-dominated markets in the northeast. We are an increasingly heterogeneous society in the organization of health care, the organization of hospital care, and the organization of health care financing. So the first summary conclusion, that all six approaches will be tried, really should be modified to say that all six will be tried in different degrees in different parts of the country.

The second and central point might logically have been made earlier, but I wanted to save it for a place where it could be appropriately emphasized. It is this: the focus of all of these utilization related activities, as indeed the focus of reponse of well managed hospitals to DRG-based payments, is the nexus between the clinical practice of medicine, the clinical provision of services, and payment for those services. That is the core of the issue. What we are doing is saying to doctors that the clinical decision is a financial decision. At the same time, the people who write the checks or cash the checks are being told that every financial act has clinical implications. I am quite convinced, on the basis of experience with people who have tried each of these six approaches, when they have done it in a thoughtful and nonhysterical, nonideological way, that if one focuses on the nexus between the clinical and the financial areas, one often can identify areas in which one can reduce cost, or at least reduce the rate of cost increases, while at the same time improving the quality of services provided to patients.

Not every increase in medical care expenditure immediately benefits any patient. Some are downright harmful. Excessively long hospital stays are not only costly but dangerous. The administration of a test from which one can only expect a tiny yield is unlikely to have very much impact on

diagnosis or prognosis, but, undoubtedly, in many instances, carries a risk greater than any benefit that might be received. There are areas, if one focuses at that nexus of the clinical and the financial, where one can identify the many instances in which good medicine is less expensive medicine. That is what we must do.

The third and final point I shall make is more on the order of a coda, where one puts the themes aside and tries to connect them to one another. That is, as one begins to talk about any of these six approaches, and begins to work with them and to live with them, and as the legislation and the actual experience relative to PROs reveals pretty dramatically, it makes less and less and less sense all the time to talk about undertaking one set of steps relative to Medicare and another set of steps relative to Medicaid, and still another set of steps relative to Blue Cross. I am familiar with all of the criticisms of so-called public utility regulation—I do not want to get into that here—and I also do not want to get into the issue here of whether all-payor price setting is public utility regulation. What I do want to suggest is maybe, if we focus on these issues of utilization and have to live with working through them, we shall come to feel increasingly, intuitively, how irrational it is to have the kind of financing system we do, in which six, eight, or nine major classes of payers cover 90% of the population, and no one covers the other 10%. And maybe we can use this as kind of backwards or sideways door to get to where we really have to go, to what is really the key issue, and that is universal access through universal financing.

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